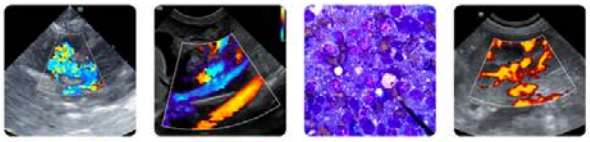


PATIENT

Murphy Williams

SPECIES

Canine

BREED

Staffy

SEX

Neutered Male

AGE

10 Years

WEIGHT

26.6 kg

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Law

INVOICE

72560

DATE

1/29/26

PRESENTING CLINICAL SIGNS

Transfer from urgent care for elevated liver enzymes. Two nights ago he vomited overnight but was fine yesterday throughout the day, then started vomiting again last night after eating dinner. Today he has been vomiting, crying, and not feeling well. Client reports he burps frequently. He has skin issues.

Previous Health Concerns Foreign body surgery in 2019 (located at stomach exit/duodenum area)

Current Medications apoquel and zyrtec

Abnormal PE/Chem/CBC/UA Results: Chemistry panel from Rossmoyne: - ALT: 4,021 (severely elevated, required 10x dilution) - ALP: 2,378 (severely elevated) - Amylase: 2,491 (elevated) - Lipase: 974 (elevated) - GGT: 16 (elevated) - Cholesterol: elevated - Total proteins: elevated - Albumin: elevated - Phosphorus: 5.8 (elevated) - Significant neutrophilia Elevated lactate Canine CPL result (ng/ml) 1496.8 Rads - No structural cause for reported vomiting detected. No obstructive dz or foreign material - No radiographic abnormalities of the hepatic silhouette identified - Bronchial pattern DDx age variance, chronic bronchitis, infectious bronchitis (e.g. viral, bacterial, fungal or other), other inflammatory bronchial pathology e.g. eosinophilic bronchitis (considered less likely) - Mild spondylosis deformans likely incidental

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi. There is an inflated foley catheter visualized in place at the trigon region, obscuring full evaluation of the trigone region and proximal urethra.

The prostate is not clearly visualized, obscured by the foley catheter.

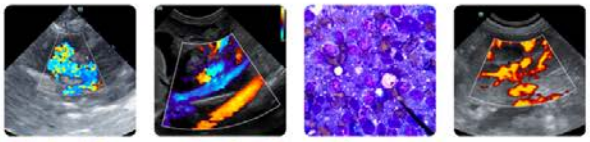
The left kidney has a normal shape and size (6.61 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.98 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.63 cm at the cranial pole and 0.73 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.



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Spleen

The spleen is subjectively normal in size (1.95 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is a poorly defined hypoechoic rounded parenchymal structure most consistent with a large nodule visualized near the gallbladder measuring 2.57 cm x 2.31 cm.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild fluid. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.34 cm. Jejunum wall measures 0.34 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is visible/mildly mottled in the left limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Visible/mildly mottled left limb of the pancreas – Findings are most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Mildly heterogeneous liver with a poorly defined, large, hypoechoic nodule visualized near the gallbladder – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less

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likely) or other hepatopathy. The nature of the hypoechoic nodule is uncertain. This could represent a benign regenerative nodule, an early mass lesion, etc.

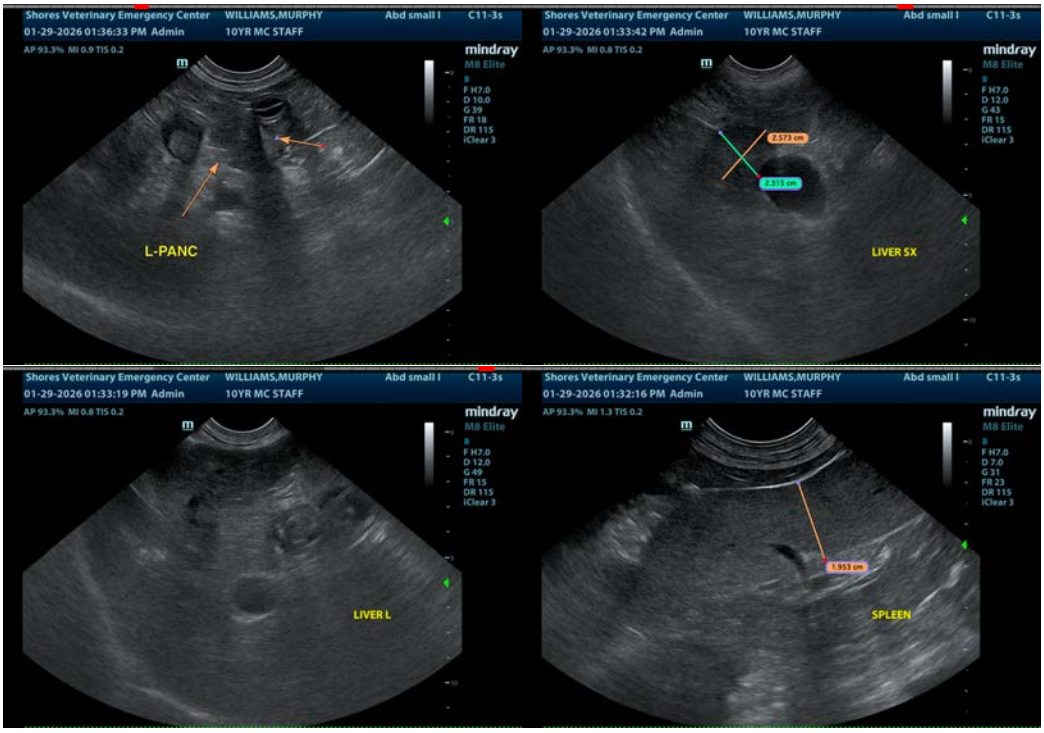
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No significant focal lesions are visualized associated with the liver to explain the elevation in liver enzymes reported. There is a large, poorly defined hypoechoic nodule visualized near the gallbladder that somewhat deforms the hepatic margins. This could represent a benign or early neoplastic lesion, but it is unlikely to be causing the acutely developing liver enzyme elevations reported. This focal lesion should be followed and possibly sampled in the future. An acute hepatopathy is suspected based on the history provided. This could be seen with a toxicity, infection, or could represent an acute presentation of a more chronic issue such as chronic active hepatitis, neoplasia, etc. Consider the following:

- Recommend pre- and post-prandial bile acids to assess liver function.
- Recommend screening for Leptospirosis.
- Fine needle aspirate could be considered to screen for round cell neoplasia or other differentials easily diagnosed with cytology (provided coagulation parameters are normal).

Recommend aggressive therapy for acute liver injury with Ursodiol, Denamarin, and antibiotics. If the patient is not improving with this therapy, biopsies of the liver may be warranted (provided coagulation parameters are normal) for histopathology, culture and copper levels.

No focal lesions are visualized associated with the GI tract. There is a mild amount of fluid in the stomach but no evidence of an obstruction at this time, although this cannot be definitively ruled out, and continued monitoring is recommended.



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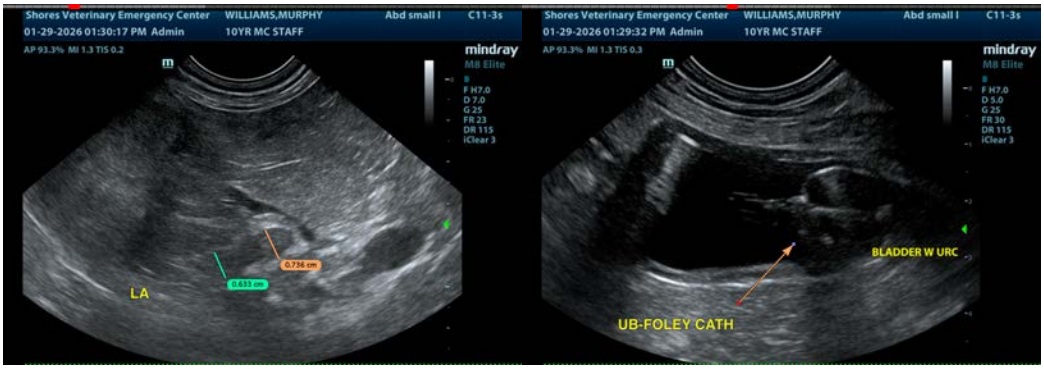

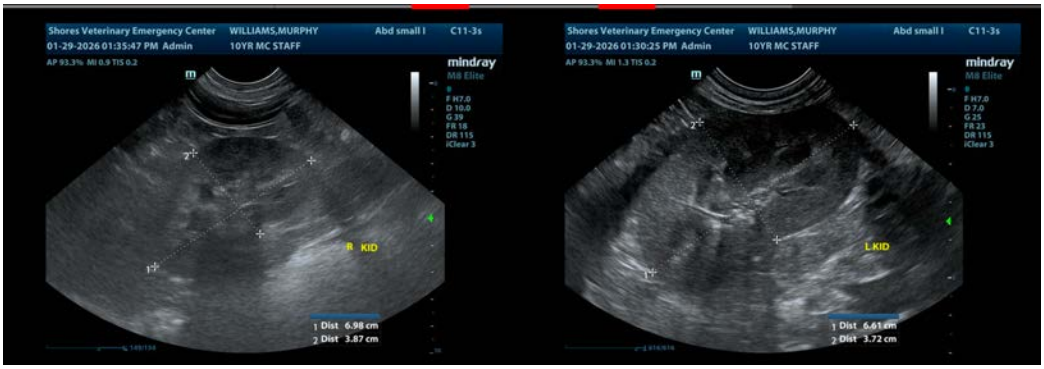

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com